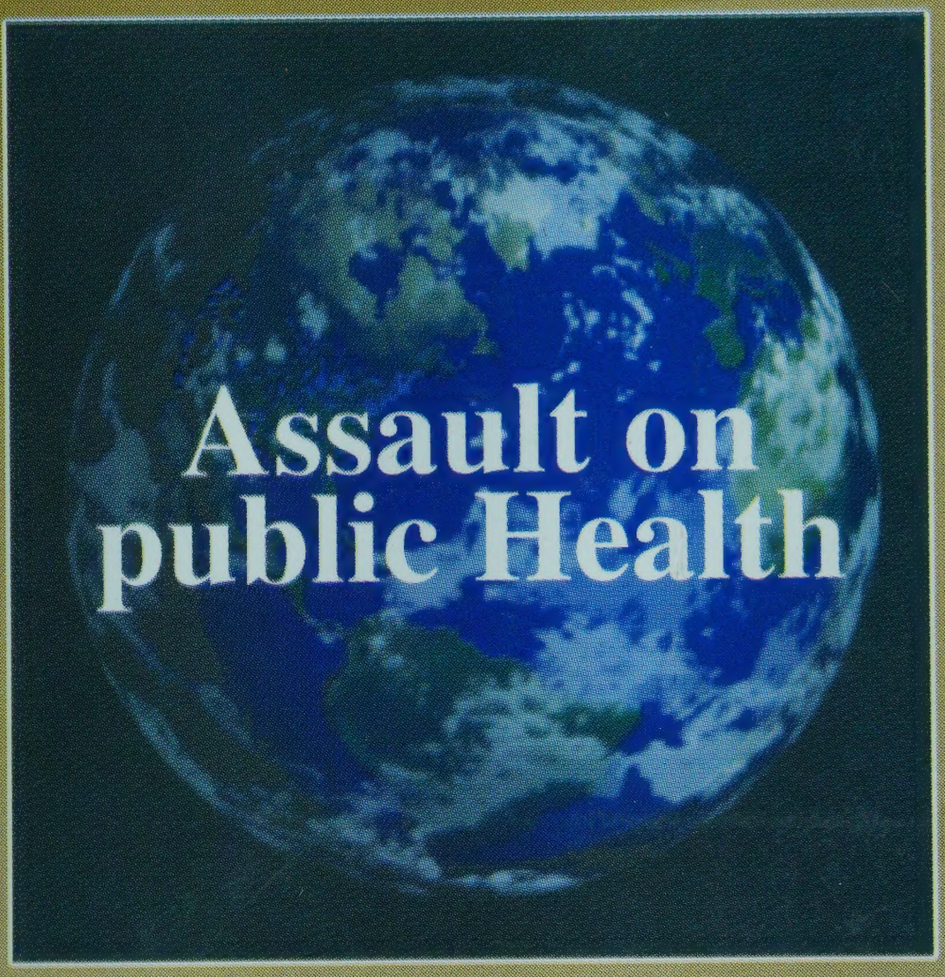
# Globalisation and the Indian people

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Globalisation and the Indian People

# ASSAULT ON PUBLIC HEALTH

All India Peoples Science Network

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# Assault on Public Health

*prepared by the All India Peoples Science Network for the World Social Forum Process in India*

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# Assault on Public Health

Globalisation is not a new phenomenon, neither is it necessarily an evil force. However what we see today in the garb of globalisation is something that is unique and unprecedented. Notwithstanding the rhetoric, globalisation has come to mean the legitimisation of neo-imperialist loot. Globalisation, as is being practiced today, does not encourage free flow of goods, ideas and people across the globe. On the contrary it perpetuates and increases monopoly control over resources, technology, knowledge and capital. The tools used are multinational corporations and finance capital, aided by the institutions of globalisation – the IMF and the World Bank, with the WTO functioning as the lawmaker who constantly changes the rules of the game to favour the rich and the powerful. We need to make a distinction between this form of globalisation and true globalisation – which would mean unhindered flow of technology, knowledge and resources to those corners of the globe which need it most. The globalisation that we see today is global only in regard to the vastly increased ability of imperialism to interfere in governance and decision-making in sovereign nations. What we have is not interdependence, but increasing dependence on a few who control productive resources and capital.

This kind of globalisation is plagued with a fundamental contradiction – in an age when restrictions on information flow and flow of goods, services and capital are sought to be removed, there is a greater concentration of wealth and knowledge in a few hands. Such concentration is manifest in growing inequalities. More than a decade back the UNICEF took note of the initial signals: "Great change is in the air as the 1990s begin ... And great change is needed if a century of unprecedented progress is not to end in a decade of decline and despair for half the nations of the world. In many countries poverty, child malnutrition and ill-health are advancing again after decades of steady retreat. And although the reasons are many and complex, overshadowing all is the fact that the governments of the developing world as a whole have now reached the point of devoting half of their total annual expenditures to the maintenance of the military and the servicing of debt". Such appeals obviously went unheeded and in the last decade of the past millennium actual per capita incomes fell in over 80 countries. This is what is unique



about the present phase – the fact that the consequences of curren policies are being felt at an unprecedented scale. Such wide-ranging reversals of social and economic gains have never happened in the history of human civilisation.

*Balance Sheet of Globalisation*

- The United Nations Development Program (UNDP) estimates that the world's 225 richest people have a combined wealth of over $1 trillion, an amount equal to the annual income of the poorest 47% of the world's people or 2.5 billion individuals.
- At least one-fifth of the world's population (1.3 billion people) live in absolute poverty with 70% of them composed of women.
- Ninety percent of the global disease burden are carried by the developing world which has access to only 10 percent of the resources for health.
- About 93% of the world's burden of preventable deaths occur in developing countries.
- Ten million children under the age of 5 and 7.4% of adults between ages of 20 and 49 die each year, the majority of whom live in developing countries
- In Europe, the risk of dying from a pregnancy-related illness is one in 1,400. In Asia, it is 1 in 65, and in Africa, it is 1 in 16.
- Millions of people like those in sub-Saharan Africa and Asia still die from communicable but preventable diseases like tuberculosis, malaria and schistosomiasis. About one-third of the world's population is infected with tuberculosis with almost 2/3 of them living in Asia. In the developing world, more women of childbearing age die from TB than from causes related with pregnancy and childbirth.
- In the developing world, 1.2 billion people lack access to safe water, adequate sanitation and poor housing; 800 million people lack access to health services.

## IMF/World Bank Dictated Policies

The seeds of this process was sown a quarter of a century back when the International Monetary Fund (IMF) introduced its infamous Structural Adjustment Programmes (SAP) in poor countries of Latin America, Africa and Asia. In brief, the Structural Adjustment Programme (SAP) was designed to:

- Cut government spending — this means big cuts in health care, education and subsidies to farmers and the poor.
- Privatisation — state owned industries and services must be sold off to private corporations. Often foreign multinationals are the buyers. Many workers lose their jobs as government industries close down. Services like transportation and power become more expensive.
- Devalue the local currency — for example, in India the rupee should be worth less and less compared to the American dollar. The World Bank and IMF demand this so that what the country exports is cheaper in the international market. The World Bank and IMF say this will increase the country's exports so it can earn foreign dollars — and pay back the loans! But farmers and local industries get less for their goods. And prices of imports go up!
- Export more — the country should export more to pay back loans. The agricultural sector should turn to commercial farming for the market and for export, rather than food production for local consumption.
- Open the door to foreign multinational companies
- Reduce duties and tariffs on imports — in this way foreign multinationals can more easily sell their products in a country like India. Local industries find it hard to compete with cheaper imports.

Recorded information proves that SAP has been detrimental to nation states in every region. In spite of this experience, the same prescriptions were applied later to nations such as India and the result have been predictable: rising prices,

inflation, rising unemployment, change in cropping patterns, loss of food security, withdrawal of subsidies on public welfare services such as public health, education and the public distribution system. These have directly and selectively affected the already 'disadvantaged' in our country. Combined with this is the larger issue of loss of sovereignty since our Parliament can no longer make policies favoring our people but at the behest of WB/IMF.

SAP induced policies led many countries to pile up huge debts which were underwritten by large capitalist banks and multilateral lending institutions. The subsequent story is strewn with even larger disasters. As country after country got caught up in a debt trap, the IMF forced further squeeze on the financing of social services. By the mid 1980s the Third World was already a net exporters of money, i.e. debt servicing was higher than the total inflow of loans, bilateral and multilateral aid, and Foreign Direct Investment. The results were felt most severely in the social sectors – health, education, food security, etc. In Tanzania, for example, debt service payments are 9 times the expenditure on primary health care and 4 times the expenditure on education. In Peru per capita food intake fell by 25% between 1975 and 1985. Somalia was ravaged by a famine that was entirely a result of IMF dictated policies (and not civil war and drought as claimed by foreign "experts") Between 1975 and 1989 health expenditure was cut by 78%. Meanwhile cheap wheat from the US and beef and diary products from the European Union disrupted the country's agriculture which had been dependant on indigenously grown maize and sorghum and local livestock. It is possible to go and on in the same vein. It has been estimated that at least six million children under five years of age have died each year since 1982 in Africa, Asia and Latin America because of SAP. The magical words of globalisation, privatisation and liberalisation have led to absolute impoverishment of millions in the third world.

Bank and IMF dictated policies also placed primacy on the necessity to be "competitive" in the global market. In order to do so poor countries were told that the poor were a liability and, at best, could be provided a "safety net". The purpose of such a net is not to provide comprehensive social security cover but to provide "minimum" facilities and services that could contain social unrest and political instability. Countries, as a result, are increasingly resorting to "social dumping", where the poor are insulated from the mainstream and kept in a permanent state of penury. Poverty figures in India, for example, indicate that rural poverty has increased in the "reform" years while at the same time the government exults over benefits of reforms that have accrued to a small affluent section. Clearly policy making today targets this small section and ignores 80% of the population.

## Public Health – a Casualty

Public health is an obvious casualty of this process. There is a clear contradiction between the principal tenets of public health and neo-liberal economic theory that permeates policy making today. The former posits that public health is "public good", i.e. its benefits cannot be individually appropriated or computed, but have to be seen in the context of benefits that accrue to the public. Thus public health outcomes are shared, and their accumulation lead to better living conditions. Such goods never mechanically translate into visible economic determinants, viz. income levels or rates of economic growth. Kerala, for example, has one of the lowest per capita incomes in the country but its public health parameters rival those in many developed countries. The Infant Mortality Rate in Kerala is less than a third of any other large state in the country. But neo-liberal economic policies are loath to even acknowledge such benefits. The current economic policies would rather view health as a private good that is accessed by the medium of the market. SAP induced economic policies had the following specific consequences for the health sector:

i. A cut in the welfare investment, leading to gradual dismantling of the public health services.

ii. Introduction of service charges in public institutions, which has now making the services inaccessible to the poor.

iii. Handing over the responsibility of health service to the private sector and undermining the rationality of public health. The private sector on the other hand focused only on curative care. India for instance, was forced to reduce its public health expenditure in health and to recover the cost of health services from its users by international banks.

iv. The voluntary sector, which has also stepped in to provide health services is forced to concentrate and prioritise only those areas where international aid is made available – like AIDS, population control, etc.

These "fundamentals" were more sharply focused upon in 1987 by the World Bank document titled "Financing Health Services in Developing

countries" The document recommended that developing countries should

1) Increase amounts paid by patients.

2) Develop private health insurance mechanisms (this requires a dis mantling of state supported health services as if free or low cos health care is available there is little interest in private insurance).

3) Expand the participation of the private sector.

4) Decentralise government health care services (not real decentralisation but an euphemism for "rolling back" of state responsibility and pass ing on the burden to local communities).

These recommendations were further "fine-tuned" and reiterated by the Bank's World Development Report, 1993 titled "Investing in Health" This document represents the Bank's major foray into health policy for mulation. Today the Bank is the decisive voice in this regard, and organisations such as the WHO and UNICEF have been reduced to playing the role of "drum beaters" of the Bank. As a Bank economist candidly reflected: "Policy lending is where the bank really has power – I mean brute force. When countries really have their backs against the wall, they can be pushed into reforming things at a broad policy level (which) normally, in the context of projects, they can't. The health sector can be caught up in this issue of conditionality"

In almost every developing country, these prescriptions have been avidly lapped up. In Philippines health expenditure fell from 3.45% of GDP in 1985 to 2% in 1993; and in Mexico from 4.7% of GDP to 2.7% in the decade of the 80s. Even developing countries with a strong tradition of providing comprehensive welfare benefits to its people were not spared (with the exception of Cuba). In China health expenditure is reported to have fallen to 1% of GDP and 1.5 million TB cases are believed to have been left untreated since the country introduced mechanisms for cost recovery. In Vietnam the number of villages with clinics and maternity centres fell from 93.1% to 75%.

## Health Sector Reform in India

India embarked on its present path of economic liberalisation, on instruc

tions from the Bank and IMF, relatively late. But in 1991 the infamous Manmohan Singh budget set things in motion. The immediate fallout was a savage cut in budgetary support to the Health sector. The cuts were severe in the first two years of the reform process, followed by some restoration in the following years. Between 1990-91 and 1993-94, there was a fall, in real terms, of expenditure on Health care both for the Centre and the states, though it was much more pronounced in the case of the states. In this period there was a compression of total developmental expenditure of state governments. Thus expenditure, in real terms, for state governments plummeted in 1991-92 and 1992-93, and just about touched the level of 1990-91 in 1993-94. This squeeze on the resources of states was distributed in a fairly secular fashion over expenditures incurred under all developmental heads. Health care was a major casualty, as the share of states constitutes a major portion of expenditure. A similar kind of squeeze in resource allocation was felt in all programmes, largely financed by the states, including water supply and sanitation. In contrast even in the worst "resource crunch" years, the almost exclusively centrally funded family planning programme fared much better.

Expenditure patterns on health care are grossly skewed in favour of urban areas. Expenditure cuts further distort this picture with the axe on investment falling first on rural health services. As a result of this rolling back of state support to health care the first major casualty in infrastructure development has been the rural health sector. There has been a perceptible slowing down in infrastructure creation in rural areas.

Compression of funds available with states has had a number of far reaching effects. Generally, expenditures on salaries tend to take up an inordinately large part of total expenditure. Salaries constitute 70-80% of expenditure for most major programmes, and the trend is most distorted in the case of rural programmes, viz. rural hospitals and primary health centres. Faced with limited funds, while salaries still require to be maintained at previous levels, the burden of cutbacks are increasingly placed on supplies and materials. Ultimately a skeletal structure survives, incapable of contributing in any meaningful manner to amelioration of ill-health. We are now seeing this as a major contributory factor to the disruption of the rural primary health care system. In GDP terns

health expenditure in the country (already one of the lowest in the world) has declined from 1.3% in 1990 to 0.9% in 1999. While Central budgetary allocation has remained stagnant at 1.3% of total outlay, the budgetary allocation to health in state budgets (which account for over 70% of total health care expenditure of the country) has fallen in this period from 7.0% to 5.5%.[7] This is a direct consequence of the squeeze imposed on the finances of the states by the economic liberalisation policies. In reaction to this, desperate state governments are queuing up in front of the World Bank to receive Bank aided projects. This is proving even more disastrous as these projects impose strict conditionalities like cost recovery.

## Cost Recovery and Health Expenditure

Cost recovery is the lynchpin of the Bank sponsored policies in the country, in spite of irrefutable evidence that such schemes, without fail, result in the exclusion of the poorest. The case for the utility of user fees uses the particularly seductive argument of equity. Seen in abstract it appears to make sense that those who can pay should, and the benefits would be shared by those who cannot. Unfortunately user fees do not work in this manner in the real world. The concept of user fees, rather, is used to legitimise the withdrawal of the state. Let us remember that the user fee argument is being forwarded in a situation where public funding of health care expenditure has fallen from 22% in the early nineties to 16% in 2000. India has one of the most privatised health systems in the world (see Table). To harp on user fees while not arguing for a quantum jump in health care expenditure by the state lets the state of the hook and shifts the basic terrain of debate on health care expenditure.

The concept of user fees uses the old and tested model of cross subsidization — some pay more to subsidise expenditure for those who pay less or nothing. This model has been used successfully in infrastructure sectors like power, telecom, air transport etc. For the model to be successful there is an assumption that a majority of users are part of the public funded system. In health care in India this is far from the case. Public facilities are utilised by those who do not have any other recourse or a powerful elite who can milk the public funded system. To expect that the latter will pay is unrealistic. As we move towards greater

| Table: Public Sector Expenditure as Percent of Total Health Expenditure | |
|---|---|
| USA | 44 |
| UK | 96 |
| *Spain* | *70* |
| Norway | 82 |
| Japan | 80 |
| Germany | 78 |
| France | 76 |
| Canada | 72 |
| Australia | 72 |
| Vietnam | 20 |
| Pakistan | 23 |
| Nigeria | 28 |
| Myanmar | 16 |
| India | 16 |
| Georgia | 13 |
| Ethiopia | 36 |
| Cote Ivoire | 38 |
| Cameroon | 20 |
| Cambodia | 14 |
| Burkina Faso | 31 |
| *Source: World Health Organisation, 2000* | |

privatisation, those who can pay (even to a limited extent) move increasingly to the private sector. This further undermines the quality of care in the public funded system, as the relatively vocal sections have lesser stakes in its survival.

Moreover the concept of user fees is a thin end of the wedge, used to legitimise greater levels of private expenditure in health care. Let us not forget that the whole argument used in favour of private participation in physical infrastructure (power, telecom, etc.) was built around the claim that it would free scarce resources for social infrastructure — health, education, PDS. In all these sectors we see a rolling back of the state and reduced expenditure. Any mechanism of cross subsidy requires an arbiter who consciously works in favour of the poor. To believe that the present Indian state is going to play this role is to delude us.

**Penetration of the Private Sector**

The abandonment of the Indian Government's basic duty in providing health care facilities has greatly enhanced the ability of the private sector to penetrate into the health sector. The distinction between health

care and medical care is important and needs to be noted. Health care involves a lot more than just medical care, i.e. diagnosis and treatment of illnesses. Health care involves nutrition, drinking water and sanitation facilities, good housing, and a lot more. These aspects of health, for obvious reasons cannot be catered to by the private sector. But what of the medical care that is provided by the private sector? There is a fundamental contradiction that exists in the concept of private medical care. By definition private medical care can survive only if it is profitable. What logically follows is that a private medical care provider stands to profit from ill-health — the more people fall ill and the longer they remain ill, the larger the profit for the care provider! The fundamental inconsistency can also be illustrated by the simple demand and supply logic of the market place. It can be legitimately argued that the demand for health care will always be infinite, for there is really no limit that one can set on good health. Thus, the demand for health care will always outstrip supply, and hence, under "free market" conditions, the cost of health care will always rise exponentially! We have commented earlier about the fact that developed Capitalist economies continue to pledge resources on public funded health care — to the tune of 70-80% of total health care costs. They do so, not out of any altruistic motives, but because conventional wisdom dictates that health care in the private sector is expensive and inefficient. And yet, our Government wishes to argue that privatisation of health care leads to more efficient utilisation of resources!

In spite of all the virtues of the "free-market" that are being sought to be foregrounded, the private sector is thriving because of a host of direct and indirect subsidies it receives from the Government. It is ironical that a Government which declares that it makes poor economic sense to "subsidise" health care for the poor, provides such subsidies to the Private and Corporate Medical Sector, which cater exclusively to the needs of the rich. Thus, after providing medical education at a very nominal cost the Government provides concessions and subsidies to private medical professionals and hospitals to set up private practice and hospitals. It may be recalled that the Apollo Hospital in Delhi was built on land provided by the Delhi Government at a throwaway price! The Government also provides incentives, tax holidays, and subsidies to private pharma-

ceutical and medical equipment industry. It allows exemptions in taxes and duties in importing medical equipment and drugs, especially for expensive new medical technologies. The government has allowed the highly profitable private hospital sector to function as trusts which are exempt from taxes, thereby exempting them from contributing to the state exchequer even while being allowed to make huge profits. Moreover, medical and pharmaceutical research and development is largely carried out in public funded institutions but the major beneficiary is the private sector. Many private practitioners are given honorary positions in public hospitals, which they use openly to promote their personal interests.

The decade of the nineties has seen another transition taking place in the private health sector. Prior to this, the private sector consisted of a large number of individual practitioners and private hospitals and nursing homes run by medical professionals. For the first time, today, we see the entry of the organised corporate sector in medical care. As the practice of medicine becomes more technology intensive, the role of the medical professional is becoming narrower. The control of technology has thus become the key factor in determining who or which entity controls private medical care. Corporate entities, given their ability to invest in "state of the art" medical technologies, are fast wresting control of the medical care "industry". Henceforth, the return on investment made by such corporations, and not any esoteric concept of professional ethics, will determine the kind of care provided. As corporates try to maximise profits they will attempt to further push up cost of medical costs by introducing high cost technologies, and expensive diagnostic aids and medicines. This is not merely an imaginary futuristic scenario. In the United States, such an approach to medical care has lead to health care costs being the highest in the world.

Alongside the move towards reduced support to health care facilities, the government's new-found fascination with health insurance is designed to facilitate privatisation of the health sector. Wary, that a total collapse of the public health infrastructure would also affect the more vocal sections of the people — the elite and the middle class — health insurance is seen as a useful ploy to replace the Govt. health sector. But such a system addresses the needs of a small fraction, because, when the Govt. today talks of health insurance, it means *private* health insur-

ance. All countries with a developed health care infrastructure have health insurance, but in most the major share is made up of by Govt. supported health insurance. For example, in Japan, France, Canada, England and Netherlands the whole or majority of the population is covered by Govt. funded health insurance. The only large country where private health insurance is dominant, is the United States — a country that has the most inefficient and expensive health care system in the developed World.

## Resurgence of Communicable Diseases

In addition to the key area of IMF/Bank induced health sector reforms, globalisation impinges on the health sector in myriad other ways. Globalisation leads to transnationalisation of public health risks. A major effect has been the resurgence of communicable diseases across the globe. Every phase of human civilisation that has seen a rapid expansion in exchange of populations across national borders has been characterised by a spread of communicable diseases. The early settlers in America, who came from Europe, carried with them small pox and measles that decimated the indigenous population of Native Americans. Plague traveled to Europe from the orient in the middle ages, often killing more than a quarter of the population of cities in Europe (like the plague epidemic in London in the fifteenth century). This is a natural consequence of exposure to local populations to exotic diseases, to which they have little or no natural immunity.

Today what incubates in a tropical rainforest can emerge in a temperate suburb in affluent Europe, and likewise what festers in a metropolitan ghetto of the global North can emerge in a sleepy village in Asia – within weeks or days. However those that are most badly affected are the poorest that live in developing countries, because their immunity is compromised by under nutrition and because they have little or no access to health facilities. In the case of AIDS the combination of global mobility and cuts in health facilities has been lethal for many developing countries – a whole generation has been ravaged by the disease in Africa, and now in Asia. Let us not forget that AIDS first manifest itself in the US, but it was Africa that feels the real force of its wrath. In the 1960s scientists were exulting over the possible conquest to be achieved over communicable diseases. Forty years later a whole new scenario is unfolding. AIDS is its most acute manifestation. We also have resurgence of cholera, yellow fever and malaria in Sub-Saharan Africa, malaria and dengue in South America, multi-drug resistant TB, plague, dengue and malaria in India. We see the emergence of exotic viral diseases, like those caused by the Ebola and the Hanta

virus. Globalisation that forces migration of labour across large distances, that has spawned a huge "market" on commercial sex, that has changed the environment and helped produce "freak" microbes, has contributed enormously to the resurgence.

## No Medicines for the Poor

While unleashing new horrors in the form of disease, globalisation has also compromised people's ability to combat them. The WTO agreement on Patents (called the Trade Related Intellectual Property Rights – TRIPS) has sanctified monopoly rent incomes by pharmaceutical MNCs. The WTO defines 'Intellectual Property Rights' as, "the rights given to persons over the creations of their minds. They usually give the creator an exclusive right over the use of his/her creation for a certain period of time." TRIPS protects the interests of big biotechnology, pharmaceutical, computer software and other businesses and imposes the cost of policing on cash-strapped governments, while slowing down or preventing altogether the transfer of useful technology.

The Trade Related Intellectual Property Rights (TRIPS) agreement, signed as a part of the WTO agreement, was the most bitterly fought during the GATT negotiations. Till 1989 countries like India, Brazil, Argentine, Thailand and others had opposed even the inclusion of the issues in TRIPS in the negotiating agenda. They did so based on the sound argument that Intellectual Property Rights — which includes Patents over medicines — is a non-trade issue. India and others had argued that rights provided in domestic laws regarding intellectual property should not be linked with trade. They had further argued that the history of IPRs shows that all countries have evolved their domestic laws in consonance with the stage of economic development and development of S&T capabilities. Laws that provide strong Patent protection limit the ability of developing countries to enhance their S&T capabilities and retard dissemination of knowledge. Japan, for example, was able to enhance its domestic capabilities through the medium of weak patent protection for decades — well into the second half of the twentieth century. Italy changed to a stronger protection regime only in 1978 and Canada as late as in 1992. It was thus natural that many countries like India had domestic laws that did not favour strong protection to Patents before the WTO agreement was signed. It was illogical to thrust a single patent

structure on all countries of the globe, irrespective of their stage of development.

These arguments were however systematically subverted during the GATT negotiations, leading to the signing of the TRIPS agreement. The TRIPS agreement required countries like India to change over to a strong patent protection regime. A regime that would no longer allow countries to continue with domestic laws that enabled domestic companies to manufacture new drugs invented elsewhere, at prices that were anything between one twentieth and one hundredth of global prices. It may be recalled that it was the 1970 Patent Act which, by encouraging Indian companies to develop new processes for patented drugs, also facilitated the development of world class manufacturing facilities in a developing country like India.

The TRIPS agreement has placed enormous power in the hands of MNCs, by virtue of the monopoly that they have over knowledge. They have generated super profits through the patenting of top selling drugs. But drugs which sell in the market may have little to do with the actual health needs of the global population — for, often, there is nobody to pay for drugs required to treat diseases in the poorest countries. Research and patenting in pharmaceuticals are driven, not so much by actual therapeutic needs, but by the need of companies to maintain their super profits at present levels. Simultaneously, new drug development has become more expensive because of more stringent regulatory laws. This is a major reason for the trend towards global mergers, as individual Cos. wishing to retain the huge growth rates of the 1970s and 80s, are trying to pool resources for R&D. As a consequence, we are looking to a new situation, where 10-12 large Transnational conglomerates will survive as "research based" Cos., that is Cos. that will be in the business of drug development and patenting.

Given their monopoly over knowledge, these companies will decide the kind of drugs that will be developed — drugs that can be sold to people with the money to buy them. Thus on one hand we have the development of "life-style" drugs, i.e. drugs like viagra, which target illusory ailments of the rich. On the other hand we have a large number of "orphan" drugs — drugs that can cure life-threatening diseases in Asia and Africa, but are not produced because the poor cannot pay for them. Today's medical research is highly skewed in favour of heart diseases and cancer as compared to other diseases like malaria, cholera,

dengue fever and AIDS which kill many more people — especially in developing countries. Just four per cent of drug research money is devoted to developing new pharmaceuticals specifically for diseases prevalent in the developing countries. To put it another way, less than 10% of the $56 billion spent each year globally on medical research is aimed at the health problems affecting 90% of the world's population. Some drugs developed in the 1950s and 1960s to treat tropical diseases, on the other hand, have begun to disappear from the market altogether because they are seldom or never used in the developed world.

## Promoting Further Privatisation through the WTO

*The General Agreement on Trade in Services (GATS)*

Historically trade agreements involved reducing tariffs, eliminating trade barriers like quotas on imports on goods produced in a country and sold elsewhere. However, this has changed drastically in recent years in as, in developed countries, manufacturing has ceased to be profitable because of global competition. Presently, the services sectors have expanded and are growing at the fastest rates in these countries. The service sectors accounts for two thirds of economy and jobs in the European Union (EU), almost a quarter of the EU's total exports and a half of all foreign investment flowing from the Union to other parts of the world. In the US, more than a third of economic growth over the past five years has been because of service exports.

As the service sectors of the economies of developed countries grew, trade in various types of services were exported. Multinational Corporations started lobbying for new trading rules that will expand their share of the global market in services as governments everywhere spend a considerable amount of their budget on social services.

This is what the General Agreement on Trade in Services (GATS) under the WTO is targetting today. GATS covers some 160 separate sectors. In the WTO meeting in Seattle, the US specifically wanted to focus on free trade in services in the professions, health and education.

The GATS as in all the other agreements contains provisions which allow further deregulation of any national legislation which is seen to be hostile to free trade. GATS identify the specific commitments of member states that indicate on a sector by sector basis the extent foreigners' may supply services in the country. The negotiating process in GATS allows for countries to decide, through 'request offer' negotiations, which service sectors they will agree to cover under GATS rules. This refers to the extent to which member states want their services like health and

education to be open up to free trade.

Today private insurance companies, managed (health) care firms, health care technology companies and the pharmaceutical industry of the developed countries are looking for opportunities to expand health care markets. In the Third World, much of private health services were by and large provided by non-governmental organisations like charities, religious societies and community oriented associations which were not entirely profit driven. This will change when health services and investments in health expand and the corporate sector is poised to play a prominent role especially in countries where there is an affluent elite willing to pay or where there exists a private health service base: like in India. This move to open up the health and social sectors to allow for privatisation and competition from the private sector will mean private corporations taking over the health and social services of countries for profit undermining the equitable distribution of health care.

*The 'Agreement' On Government Procurement*

Under the proposed 'Agreement on Government Procurement Policy' the developed countries wants to introduce a process in the WTO whereby their companies are able to obtain a large share of the lucrative business of providing supplies to and winning contracts for projects of the public sector in the Third World. The aim is to bring government spending policies, decisions and procedures of all member countries under the umbrella of the WTO, where the principle of 'national treatment' will apply. Under this principle, governments would no longer be able to give preferences or advantages to citizens or local firms. Through the government procurement issue, the North will enable its corporate bodies to tap the vast public resources available in the health and social services sector and dismantle the public provision of health care. Public procurement will be the golden goose providing the crucial link to open up the services sector.

*The 'Agreement' on Competition Policy*

Privatisation of health care will also be facilitated under the proposed 'Agreement on Competition Policy'. Member states 'will have to consider making reforms to their regulatory regimes' such that national regulations should have four central attributes: adequacy, impartiality, least

intrusiveness and transparency', towards corporate interests. Under such an agreement, Third World countries would be forced to establish domestic competition policies and certain type of laws. Distinctions that favour local firms and investors would not be allowed. For example, if there are policies that give importing or distribution rights (or more favourable rights) to local pharmaceutical companies (including government agencies or enterprises), or if there are practices among local firms that give them superior marketing channels, these are likely to be targeted and even banned. If smaller Third World enterprises were treated on par with the large foreign conglomerates, they would not be able to survive. The North will insist that their giant firms be provided a 'level playing field' to compete equally with smaller domestic companies. Competition of this type will invariably lead to foreign monopolisation of Third World markets.

*The 'Agreement' on Investment*

Similarly on the investment issue, the Northern governments want to introduce new rules that make it legal to give foreign investors the right to enter and establish themselves with 100 percent ownership. Governments then will lose the right to regulate investment to achieve and protect social, environmental and health well being in the national interest both long term and short term.

*Corporations Shape Health*

Already policies promoted by the IMF and the world Bank have created the conditions for the expansion of privatised health care and the dismantling of public health services in the Third World. Different provisions under the WTO that are still being negotiated will force countries to remove all barriers to foreign participation in their health and social services sector.

If Third World countries commit to fully cover health services under the existing GATS rules, this will lead to irreversible changes in the financing and delivery of health and social services. Governments will have to open up their health sectors to foreign health service providers. Foreign health suppliers are guaranteed access to the health services market, which includes the right to invest, to provide health services from abroad and to send health professionals to practise. Any preferential treatment for local hospitals, nursing and handicapped homes, etc. will have to be eliminated or given to foreign service provid-

ers. Requirements that first preference be given to locals will be eliminated Conditions must be created for the private health sector to provide or supply any service (like resorts, spas, exotic therapies, laundry, food catering, cleaning health management consultancies, etc.); the private sector will effectively tap funds that the government spends on health by directing government spending towards the private sector in this way funding the privatised health services.

## Targeting Women in A Globalised World

Public Health professionals have consistently argued that women's health is not just considerations related to pregnancy, child birth and control of fertility. However it is precisely these concerns that drive government programmes and approaches towards women's health. This drive has, in fact, accelerated in recent years. Thus the key thrust in policies remain in the area of Family Planning, and now in what is termed as "Reproductive Health".

*Development is the Best Contraceptive*

Experiences within, as well as outside the country, show that a reduction in population growth rates follow overall socio-economic development. Except in conditions of war and famine they seldom precede such development. Yet this has largely been ignored during our planning process, possibly as it prevents our planners from blaming the country's tardy development rates on the pressures posed by population increase. As a result family planning strategies have tended to be paternalistic, prescriptive and coercive. It is a strategy which starts from the belief that the poor breed prodigiously and it is the nation's duty to cap their unbridled fertility. Thus programmes are aimed at the poorest sections and more specifically at women. Tubectomy rates in the country are fifty to hundred times higher than vasectomy rates, though the latter is a far simpler and safer procedure. Hormonal methods aimed at women find precedence over propagation of condoms, in spite of widespread reports that the former are associated with a large number of health hazards. In this whole process the supposed beneficiary - the impoverished rural woman - has virtually no choice. She is at the receiving end of technologies which the state or society believe are necessary. Such programmes are inappropriate not only because they victimise women

but also because they do not work.

Such a strategy has undermined the effectivity of the general health care infrastructure as well as the faith that women have in this infrastructure to address their real concerns. Most programmes, have tended to view women as assembly line appendages required to produce babies. Thus a woman's health becomes important only when she is pregnant or lactating. But in India 65% of deaths in women are due to infection related causes and only 2.5% of deaths are related to childbirth. Even among women in the reproductive age group only 12.5% of deaths are due to childbirth associated causes.

*Chain of Coercion*

Population policies funded or dictated by the North, look for numbers as the ultimate bottom-line, not at esoteric statistics of empowerment and development. This agenda on population control, flows from fears in the Developed countries of North America and Europe that the resources of the planet will not be able to keep pace with the current rate of consumption. We are being made to believe that large population growth rates in the South is responsible. Yet the hidden agenda is related to the fact that the developed North is unable or even unwilling to curb the consumption patterns in their countries. Each child born in North America consumes as much energy as 3 Japanese, 6 Mexicans, 12 Chinese, 33 Indians, 147 Bangladeshis, 281 Tanzanians or 422 Ethiopians. The key factor in determining population impact on environment and other global resources is the number of households, rather than the number of people, because an increase in households correlates to a dramatic increase in energy use, which drains resources and compounds pollution. Household numbers are on the rise in the developed world, due to divorce, increased life expectancies, and more elderly and single people living alone.

Yet we are told that the poor nations of the Third World are the culprits who must listen to the voice of reason emanating from the corridors of power in Europe and America. The locus of coercion does not stop here. Third World nations, eager to implement population policies, pass on the burden of these programme to the poorest sections. All part of the familiar argument that the poor 'breed' too fast and that is the root

cause of their poverty. Finally, the ultimate victims (not beneficiaries) of population programmes are poor illiterate women. Thus a bulk of strategies for population control target women. This completes the **chain of coercion** - from the global North to the underdeveloped nations of the South, from the Govts. of these nations to the poorest communities, and ultimately women in these communities.

*Reproductive and Child Health*

In an attempt to legitimise the population programme in the country, the Ministry of Health and Family Welfare now claims to have adopted a target free approach. It now talks of a new Reproductive and Child Health (RCH) package, which shall replace earlier mechanisms. The essential coercive content of the family planning programme has, thus, been kept intact. As the name itself suggests, the concerns are with reproduction and not health. The gaze of the programme is still firmly fixed at women as targets.

The "new" approach to women's health has actually been borrowed from the World Bank Report *"India's Family Welfare Program: Toward a Reproductive and Child Health Approach"* (1995). Policies of sovereign Governments are today dictated by World Bank, and it is hence important to understand the thrust of this document to understand the real motivations of the Govt.'s policy. As is the Bank's forte today, the document borrows heavily from terms in vogue among serious critics of India's Family Planning Programme. Unfortunately this does not translate easily into sharing the same concerns.

The real intent of the "new" approach becomes transparent when the goals are seen to be subservient to "broad social policy" and "demographic objectives" in the following manner in the World Bank document :

*"The new consensus recognizes that an important goal of reproductive health programs should be to reduce unwanted fertility safely, thereby responding to the needs of individuals for high quality services, as well as to demographic objectives."*

*"While fertility reduction concerns can be addressed at the level of broad social policy, the design and management of reproduc-*

*tive health programs need to be directed primarily at the needs of actual and potential clients."*

This is the crucial place where the Bank's prescriptions fundamentally differ from the concept of Reproductive Health as conceived by the feminist movement in the West. In the latter case Reproductive Health, as a genuine concern among a large body of women, stands on its own and is not seen as a means to an end. Here the logic is turned on its head and under the guise of addressing women's concerns the agenda of Reproductive Health is seen as a method of attaining objectives set by faceless financial institutions and governments. The program thus fails in its first test of being able to break the first link in the chain of coercion. The links in the chain of coercion in fact are sought to be strengthened and not weakened.

The report needs to be commended for the remarkable consistency in approach with the Bank's World Development Report 1993, *Investing in Health*. There too the primary concerns were cost effectiveness and targeting. The concern, clearly articulated in both documents is to choose interventions which provide best value for money and not necessarily where the burden of disease is the greatest.

Thus anaemia is seen as a problem for women only when they are pregnant or lactating. On the other hand growth monitoring and supplementary feeding are not cost-effective. This needs to be viewed in the context that 88% of women in India are anaemic and 53% of children under five suffer from some degree of malnutrition - both figures are the highest in the world with the possible exception of Bangladesh. Anaemia in women is not just a consequence of reproductive ill-health - it is a function of diverse factors including discrimination of the girl child, undernutrition and social taboos. Child malnutrition is possibly the greatest tragedy of post-Independent India with 2/3rds of its population being maimed in its initial formative years and being consigned to a handicapped existence the rest of their lives. What in essence the Bank is proposing is a caricature of Reproductive and Child Health designed according to its peculiar logic.

The Child Health Programme was added to the Family Planning Programme in the post-Emergency days when a major refurbishing of the image of the programme had become a necessity for its very survival. The only real component of the Child Health Programme has been immunisation, to the almost total exclusion of other interventions (with

the possible exception of the largely ineffective diarrhoeal disease control programme).

Instead of strengthening existing health infrastructure, the World Bank report recommends drawing away more resources from it for family planning. The document, again consistent with the Bank's old positions, makes a strong plea for greater role for the private sector - including privatisation of Primary Health Centres and involvement of PMPs. Contracting out PHCs to the private sector can only allow profiteering. How this shall serve the so called "client" base identified by the Bank is obscure.

*Flawed Policy on Women's Health*

Finally, a word about the basic philosophy that guides policies for improving women's health - the basic assumption that women's health status in India is low because they bear too many children. The Table gives comparisons of some Developing nations as regards fertility rates (i.e. average no. of children born to women), maternal mortality rate (no. of maternal deaths due to child birth for 100,000 births), prevalence of anaemia among women and prevalence of child malnutrition. The latter (child malnutrition) is a direct consequence of maternal malnutrition, and is a sensitive indicator of the nutritional status of women.

The figures clearly show that developing countries from S.America, Asia and Africa with significantly higher fertility rates are able to demonstrate much better health conditions for their women. But policy makers at the highest levels in this country are supremely indefferent towards such evidence. For, their concerns and perceptions are no different from those of foreign donor agencies and developed nations of the West. For them, the bogey of population is a convenient ploy to hide the class and social bias of the Indian state, which discriminates against poor women, both because they are poor and because they are women.

## Assault on Food Security

The present phase of globalisation also has grave consequences for food security, which is an integral part of good health. The Agreement on Agriculture (AoA), under WTO has further skewed the balance against developing countries. India is just beginning to feel the rigours of the Agreement on Agriculture that was part of the WTO agreement of 1995. Specifically, the lifting of restric-

**Table: Comparitive Statistics on Women and Child Health**

| | Fertility Rate | Maternal Mortality Rate | % of women suffering from anaemia | Percent of children below 5 years who are malnourished |
|---|---|---|---|---|
| Algeria | 3.6 | 160 | — | 13 |
| Botswana | 4.7 | 250 | — | 15 |
| El Salvador | 3.8 | 300 | 14 | 11 |
| Guatemala | 5.1 | 200 | — | 27 |
| Honduras | 4.6 | 220 | — | 18 |
| Nicaragua | 4.8 | 160 | — | 12 |
| Paraguay | 4.1 | 160 | — | 4 |
| Saudi Arabia | 6.2 | 130 | 23 | — |
| Syria | 5.6 | 180 | — | 12 |
| Malayasia | 3.4 | 80 | 36 | 23 |
| Vietnam | 3.7 | 160 | — | 45 |
| Zimbabwe | 4.8 | 570 | — | 16 |
| S.Africa | 4.0 | 230 | — | 9 |
| Egypt | 3.7 | 170 | 75 | 9 |
| Iraq | 5.5 | 310 | — | 12 |
| Libya | 6.2 | 220 | — | 5 |
| Pakistan | 5.9 | 340 | — | 38 |
| India | 3.6 | 570 | 88 | 53 |

*Note : — denotes figures not available*
*Source: Human Development Report, 1997*

tions on imports, as required by the AoA has resulted in widespread disruption of the rural economy. The spate of suicides by farmers in many states is a testimony to the grim situation that is fast unfolding before us. The AoA ensured that subsidies provided to domestic agriculture by developing countries would be phased out while those being provided by developed countries would be retained. This has resulted in exports of primary commodities by developing countries becoming uncompetitive while their domestic markets are being flooded by subsidized imports from developed countries. This has been compounded by pressures of the SAP induced policies to produce for the export market. As a result vast tracts in India now grow "cash" crops like cotton, tobacco, sun-

flower, etc. We in India would recall the devastation and violent reactions that were provoked by forced indigo cultivation in Bengal in the nineteenth century. The actors have not changed, only the excuses offered have! Because the global rules of the game are controlled by a few developed countries, in the past decades the global prices of agriculture exports from developing countries have fallen steadily. As a result farmers get less and less for their products, while the growth in production of staple food grains has fallen sharply. All these pose a major threat to the sustainability of agriculture in the Third World and to the safeguarding of food security.

Control over global agriculture is sought to be exercised by other means too. MNCs are pushing through a regime that will allow Patenting of seeds. At the same time they are using Biotechnology to research new varieties that are genetically modified. These two measures can allow virtual monopoly to such MNCs over seed production, and consequently total control over agriculture. If allowed, a handful of companies will decide who will grow what and what will be consumed in the globe. The implications are clear!

## Environmental Degradation and Unhealthy Lifestyles

Globalisation has also set in motion a variety of unsafe and hazardous practices. The present global division of labour has led to the dumping of hazardous wastes and the whole scale relocation of hazardous industries to developing countries. A World Bank economist, Lawrence Summers, aptly sums up the trend: "I think the economic logic behind dumping a load of toxic waste in the lowest wage country is impeccable... I've always thought that under populated countries in Africa are vastly under polluted; their air quality is vastly inefficiently low compared to Los Angeles or Mexico City"

The consumerist culture that is encouraged by corporate led globalisation has also put the long-term sustainability of the planet in jeopardy. Excessive fossil fuel use has already led to the threat of "global warming". Unregulated use of refrigerants has led to depletion of the protective ozone layer, exposing people to the deadly effects of the sun's radiation. Alongside this, corporates continue to pillage the biological resources of the globe, leading to the disappearance of a number of species of plants and animals. This has disrupted the ecology of the land and the sea. If the trend continues, the globe as we know it, may cease to exist a hundred years from now.

The same consumerist culture has led to unhealthy lifestyles – sedentary habits, preference for unhealthy "junk foods", over-indulgence in addictions like tobacco and alcohol, etc. Globalisation encourages trade in unhealthy prod-

ucts – alcohol, tobacco, baby foods. As a consequence people in the third world are suffering from the ill effects of "development" superimposed on the problems of underdevelopment.

## Reversing the Trend

Can these trends be reversed? We sincerely believe that they can. Primarily because of the contradiction that we talked about in the beginning of the booklet. Precisely because we are in an age when communications and exchange is so much easier, the contradiction can be resolved only if we move towards true globalisation. Globalisation of ideas, knowledge and resources that are controlled by a majority for the majority. It is only this which can counter what is being called globalisation today, but which is in essence its antithesis.

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**ANNEXURE**

## Policy Guidelines for World Social Forum — India

1. The World Social Forum is an open meeting place for reflective thinking, democratic debate of ideas, formulation of proposals, free exchange of experiences and interlinking for effective action, by groups and movements of civil society that are opposed to neo-liberalism and to domination of the world by capital and any form of imperialism, and are committed to building a world order centred on the human person.

2. The World Social Forum at Porto Alegre - held from January 25th - 30th, 2001, was an event localized in time and place. With the Porto Alegre Proclamation that "another world is possible", it becomes a permanent process of seeking and building alternatives, which cannot be reduced to the events supporting it.

3. The World Social Forum is a world process. All the meetings that are held as part of this process have an international dimension.

4. The alternatives proposed at the World Social Forum stand in opposition to a process of capitalist globalisation commanded by the large multinational corporations and by the governments and international institutions at the service of those corporations' interests. They are designed to ensure that globalisation in solidarity will prevail as a new stage in world history. This will respect universal human rights, and those of all citizens - men and women - of all nations and the environment and will rest on democratic international systems and institutions at the service of social justice, equality and the sovereignty of peoples.

5. The World Social Forum brings together and interlinks only organisations and movements of civil society from all the countries in the world, but intends neither to be a body representing world civil society nor to exclude from the debates it promotes those in positions of political responsibility, mandated by their peoples, who decide to enter into the commitments resulting from those debates.

6. The meetings of the World Social Forum do not deliberate on behalf of the World Social Forum as a body. No one, therefore, will be authorized, on behalf of any of the editions of the Forum, to express positions claiming to be those of all its participants. The participants in the Forum shall not be called on to take decisions as a body, whether by vote or acclamation, on declarations or proposals for action that would commit all, or the majority, of them and that propose to be taken as establishing positions of the Forum as a body.

7. Nonetheless, organisations or groups of organisations that participate in the Forum's meetings must be assured the right, during such meetings, to deliberate on declarations or actions they may decide on, whether singly or in coordination with other participants. The World Social Forum undertakes to circulate such decisions widely by the means at its disposal, without directing, creating hierarchies, censuring

or restricting them, but as deliberations of the organisations or groups of organisations that made the decisions.

8. The World Social Forum is a plural, diversified, non-confessional, non-governmental and non-party context that, in a decentralized fashion, interrelates organisations and movements engaged in concrete action at levels

— from the local to the international — to built another world. It thus does not constitute a locus of power to be disputed by the participants in its meetings, nor does it intend to constitute the only option for interrelation and action by the organisations and movements that participate in it.

9. The World Social Forum asserts democracy as the avenue to resolving society's problems politically. As a meeting place, it is open to pluralism and to the diversity of activities and ways of engaging of the organisations and movements that decide to participate in it, as well as the diversity of genders, races, ethnicities and cultures.

10. The World Social Forum is opposed to all authoritarian and reductionist views of history and to the use of violence as a means of social control by the State. It upholds respect for Human Rights, for peaceful relations, in equality and solidarity, among people, races, genders and peoples, and condemns all forms of domination and all subjection of one person by another.

11. The meetings of the World Social Forum are always open to all those who wish to take part in them, except organisations that seek to take people's lives as a method of political action and those organisations that exclude groups/ communities based on ethnic, racial, religious or caste consideration from the democratic world.

12. The WSF process in India must necessarily make space for all struggling sections of society to come together and articulate their struggles and visions, individually and collectively, against the neo- liberal economic agenda of the world and national elite, which is breaking down the very fabric of the lives of ordinary people all over the world and marginalizing the majority of the world people, keeping profits as the main criteria of development rather than society and destroying the freedoms and rights of all women, men, and children to live in peace, security, and dignity. It must make space for workers, peasants, indigenous peoples, dalits, women, hawkers, minorities, immigrants, students, academicians, artisans, artists and other members of the creative world, professionals, the media, and for local businessmen and industrialists, as well as for parliamentarians, sympathetic bureaucrats and other concerned sections from within and outside the state. Most importantly, it must make space for all the 'sections' of society that remain less visible, marginalized, unrecognised, and oppressed.

13 In India today, all civil and political organisations/groups that are organising around people's issues — economic, political, social, and cultural — are being profoundly challenged by the religious and political intolerance that is raging in the country, and increasingly across the world. There is the threat of growing communal fascism

and fundamentalism. The WSF India will strive to encourage a process that allows all of those who are combating communal fascism and fundamentalism to come together, to hear and understand each other, to explore areas of common interest, and also our differences, and to learn from the experiences and struggles of people here and in other countries.

14. The WSF India process involves not only events but also different activities across the country. These processes, in the spirit of the WSF, would be open, inclusive and flexible and designed to build capabilities of local groups and movements. The process should also be designed to seek and draw out peoples' perceptions regarding the impact of neo-liberal economic policies and imperialism on their daily lives. The language of dissent and resistance towards these will have to be informed by local idioms and forms.

15. As a forum for debate, the World Social Forum is a movement of ideas that prompts reflection, and the maximum possible transparent circulation of the results of that reflection, on the mechanisms and instruments of domination by capital, on means and actions to resist and overcome that domination, and on the alternatives that can be proposed to solve the problems of exclusion and inequality that the process of capitalist globalisation currently prevalent is creating or aggravating, internationally and within countries.

16. As a framework for the exchange of experiences, the World Social Forum encourages understanding and mutual recognition among its participant organisations and movements, and places special value on all that society is building to centre economic activity and political action on meeting the needs of people and respecting nature.

17. As a context for interrelations, the World Social Forum seeks to strengthen and create new national and international links among organisations and movements of civil society, that - in both public and private life - will increase the capacity for social resistance to the process of dehumanisation the world is undergoing and reinforce the humanizing measures being taken by the action of these movements and organisations.

18. The World Social Forum is a process that encourages its participant organisations and movements to situate their actions as issues of world citizenship, and to introduce onto the global agenda the change-inducing practices that they are experimenting in building a new world.

# Globalisation and the Indian people

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